MHIP
Maryland Health Insurance Plan

MARYLAND HEALTH INSURANCE PLAN
ANNUAL REPORT
For Period July 1, 2013 through June 30, 2014

Providing health insurance for medically uninsurable Marylanders since 2003

December 2014

MHIP
Maryland Health Insurance Plan

Honorable Martin O'Malley, Maryland State Governor
Members of Maryland State Senate
Members of Maryland House of Delegates

On behalf of the Board of Directors of the Maryland Health Insurance Plan (MHIP), I am pleased to present this Annual Report. The report summarizes the Maryland Health Insurance Plan's operations for fiscal year 2014 (FY14).

With the implementation of the Affordable Care Act (ACA) of 2010, MHIP has been actively planning and preparing for the transition of its population into other healthcare insurance options. In 2013, the MHIP Board of Directors made the decision to stage the transition of the MHIP population to the commercial market over a period of time in order to provide a sufficient transition period for this high-risk, vulnerable population. During FY 14 members in Federal pre-existing condition plans and MHIP + subsidized plans were transitioned to new health plans. In addition, the MHIP was able to provide a health plan to individuals in the MHIP Bridge program authorized through emergency legislation in January 2014.

MHIP has and continues to be a vital resource for Marylanders who otherwise would not have medical insurance. As executive director, I am quite proud of the MHIP staff and our community stakeholders who worked tirelessly to ensure MHIP members were able to transition to a new health plan without a gap in coverage. Our members express sadness for the loss of MHIP and express gratitude for what it has meant for them.

MHIP commends the State Legislature for passing emergency legislation in January 2014 that allowed 137 Marylanders to obtain health insurance while troubles through the Exchange were worked out.

As the MHIP agency winds down it operations and looks toward dissolution in 2016, we are very happy of the legacy of having provided quality health insurance for Marylanders for over ten years.

I am available to answer any questions or to provide additional information at (410) 576-2056 or michele.eberle@maryland.gov

Sincerely,

Michele Eberle

Michele Eberle
Executive Director

Maryland Health Insurance Plan

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Extensive additional information regarding MHIP is available on the MHIP website at ***www.marylandhealthinsuranceplan.state.md.us***.

History and Purpose of the Pool

MHIP is the State's high-risk pool whose purpose is to decrease uncompensated care costs through access to affordable comprehensive health benefits for medically uninsurable residents of Maryland. MHIP was created by the Health Insurance Safety Net Act of 2002 as an independent unit of the Maryland Insurance Administration and became operational on July 1, 2003. Pursuant to Chapter 259, Acts of 2008, MHIP became an independent unit of the state government on October 1, 2008.

Effective January 1, 2014, The Patient Protection and Affordable Care Act of (ACA) prohibits individuals from being denied health coverage due to a pre-existing condition. The ACA also affords premium tax credits and cost-sharing reductions to qualified individuals to lower the impact of health care costs. In 2010, the ACA established a Pre-existing Condition Insurance Plan (PCIP) as a temporary measure with a sunset date of December 31, 2013 to address those individuals who had pre-existing conditions and could not get coverage before the ACA set in.

The implementation of the Affordable Care Act eliminates the need to provide health benefits for medically uninsurable residents of Maryland. The Maryland Health Progress Act of 2013 (HB228) required closure of enrollment in MHIP, including reenrollment of former enrollees, as of December 31, 2013. The MHIP Board of Directors voted to terminate all MHIP plans effective December 31, 2014.

Structure and Administration

Board of Directors

MHIP is governed by a ten-member board of directors, consisting of the Secretary of the Department of Budget & Management, the Secretary of the Department of Health and Mental Hygiene, the Executive Director of Health Services Cost Review Commission, the Executive Director of the Maryland Health Care Commission, an insurance carrier representative, an insurance producer representative, a minority owned business representative, a hospital representative, and two consumer members. The Board is required to establish a standard benefit package and associated premium rate to be charged for coverage by MHIP.

Executive Director and Staff

An Executive Director and a staff of eight (8) employees oversee the day-to-day operations of MHIP. The staff consists of a Controller, Director of Data Analysis and Planning, an Attorney, a Staff Accountant, Manager of Human Resources, Health Data Analyst and an Executive Assistant.

Third Party Administrator
MHIP contracts with a Third Party Administrator – CareFirst of Maryland, Inc. – to perform health plan enrollment, premium billing, claims processing, customer service, on-line information access, accounting and reporting, pharmacy services through a sub-contractor , provider network, care management and other services.

Eligibility and Plan Services

Plan Eligibility Requirements
An individual was eligible to enroll in MHIP if the individual was a resident of Maryland and:

- was unable to obtain substantially similar coverage from a health insurance carrier due to a health condition;
- was unable to obtain substantially similar coverage from a health insurance carrier due to a health condition, except at a rate that exceeded the MHIP rate;
- had federal guaranteed-issue rights under the Health Insurance Portability and Accountability Act (HIPAA) of 1996;
- had a medical or health condition that was included on a list of conditions adopted by the Board by regulation;
- was eligible for the 65 percent Health Care Tax Credit under §35 of the Internal Revenue Code, including former workers and retirees of Bethlehem Steel and Black & Decker; or
- was a dependent of an individual who was eligible for coverage.

Due to the implementation of the Affordable Care Act (ACA) of 2010, the MHIP Board of Directors made the decision to cease new enrollment in the MHIP as of 12/31/13. The Board also made the decision to cease offering healthcare insurance and to terminate all members' insurance coverage effective 12/31/14. Approximately 8,000 MHIP members enrolled will be required to enroll in new healthcare insurance plans. The MHIP has developed a Transition Plan that is a concerted effort to inform and assist the MHIP population with the transition from the MHIP to new healthcare insurance plans.

Benefit Plans
The Plan offered multiple benefit options that a Subscriber could choose at the time of initial enrollment or during the annual open enrollment period. By law, premiums for all plans were required to be at least 10% and not greater than 50% higher than the average in the market. In fiscal year 2014 (June 2013-July 2014) MHIP offered the following plans:

MHIP Standard Plans

- PPO Plans: $500 and $1,000 deductible plans. PPO plans provide a higher benefit level for in network providers.
- Health Savings Account (HSA) Qualified Preferred Provider Plan: a High Deductible Plan with a $2,600 combined medical/Rx deductible that can be used with a HSA to pay for health care services with pre-tax dollars.
- Health Maintenance Organization (HMO) – least amount of out of pocket costs.
- Healthy Blue Triple Option – multiple option plan offered by CareFirst.

MHIP+ Plans

Due to the implementation of the ACA of 2010, the MHIP Board of Directors made the decision to discontinue offering the MHIP+ plans as of 03/31/14. Approximately 6,000 MHIP members enrolled in MHIP+ plans were required to enroll in new healthcare insurance plans. The MHIP made a concerted effort to inform and assist the MHIP+ population with the transition from MHIP to new healthcare insurance plans.
The MHIP+ Plans that were offered through 03/31/14 were:

- PPO Plans: $200 and $500 deductible plans.
- HMO Plan

MHIP Federal - Pre-Existing Condition Insurance Pool (PCIP)

MHIP administered the PCIP plans that were created through the ACA. MHIP provided State funded premium subsidies for Maryland residents. MHIP Federal was offered to individual applicants only. The individual premium rates were determined by the age of the subscriber and apply to individual applicants only. Per HHS directions, new enrollment into the MHIP Federal plans was closed as of 05/01/13 and all the MHIP Federal plans ceased offering healthcare insurance as of 04/30/14. The plan benefit options up to 04/30/14 included:

- PPO Plan: $500 deductible plan.
- HDP: $1,500 high deductible plan.

MHIP Bridge Program

On January 30, 2014 Governor Martin O'Malley signed Senate Bill 134 - Maryland Health Insurance Plan – Access for Bridge Eligible Individuals. The bill allowed "Bridge Eligible Individuals" as defined in § 31-101 of the Maryland Insurance Article to obtain temporary health insurance through the Maryland Health Insurance Plan (MHIP) with retroactive coverage. The MHIP Bridge Program provided a safety net for 137 Marylanders who faced obstacles in obtaining healthcare insurance during the first quarter of 2014. The MHIP Bridge Program healthcare coverage ended on 04/30/14.

Transition Strategy for MHIP+, MHIP Federal and MHIP Bridge Members

A comprehensive communication and outreach program was implemented to ensure all MHIP members were aware of the pending termination to their MHIP plans and informing them of the need to obtain new healthcare insurance. The plan included communication through the following methods:

- Letter campaigns
- Email campaigns
- Automated and direct phone calls
- Information on MHIPs website and social media outlets
- Participation at enrollment fairs
- Collaboration with the Maryland Health Benefit Exchange call center, insurance producers, other State agencies and key stakeholder.

Working in collaboration with the Maryland Health Benefit Exchange, MHIP was able to identify MHIP members that transitioned to a new plan through the Exchange.

Potential MHIP members to enroll	
Enrolled in a Qualified Health Plan	1371
Enrolled In Medicaid	1442
Unable to identify if enrolled in new plan	2721
*could have purchased direct from a carrier or obtained coverage elsewhere (i.e. employer, spouse)	

MHIP surveyed members who did not obtain new coverage through the Exchange and was able to ascertain that 90% of those surveyed had successfully enrolled in a new health plan.

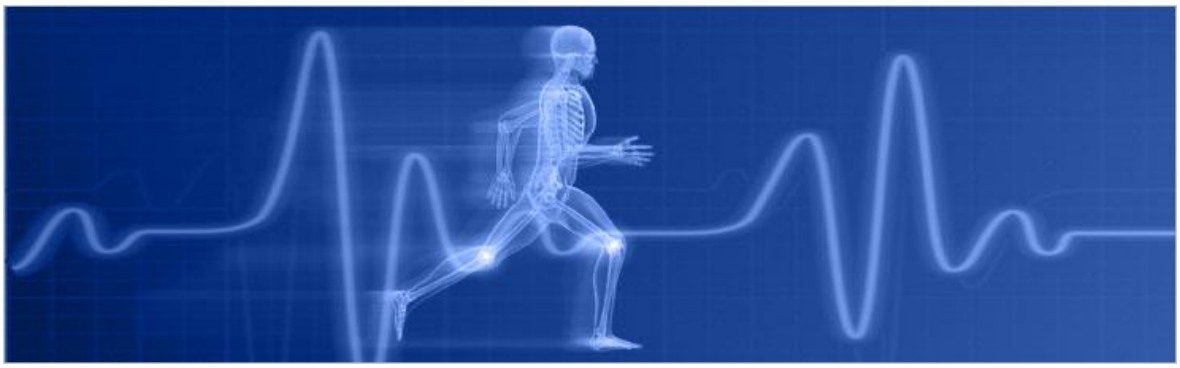
2014 Plan Highlights

MHIP State Plans

- Medical costs of $132M decreased 5.5% in FY 2014.
- PMPM of $665 decreased 14.6%.
- Pharmacy costs of $66M increased 4% in FY 2014.
- PMPM of $330 increased at 12.6%.
- Diabetes and Coronary Artery Disease represent the top two chronic conditions for the State population.
- Participation rates for preventive care screenings are higher than the CareFirst Book of Business for all metrics except Well Child Care.
- The State population represents 90.5% of total major diagnostic category spend.
- High Cost Claimants (defined as members with claims greater than $75k) represented 2% of total membership and 34.5% of spend.

MHIP Federal Plans

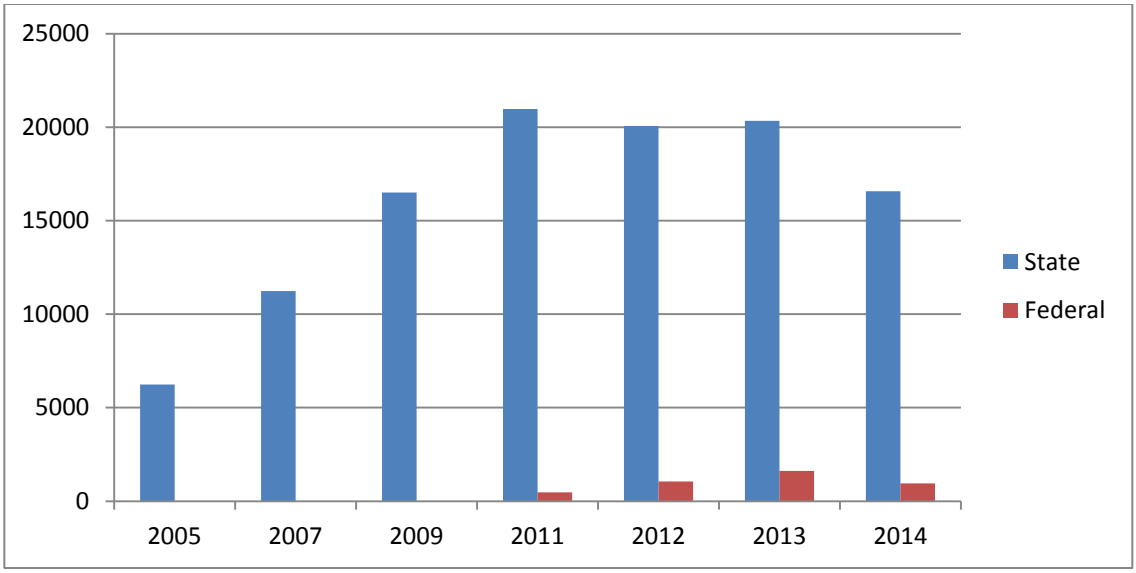
- Medical costs of $14M decreased 29% in FY 2014.
- PMPM of $1,234 increased 7%.
- Pharmacy costs of $2.6M decreased 19% in FY 2014.
- PMPM of $230 increased 21.5%.
- Diabetes and Coronary Artery Disease represent the top two chronic conditions for the Federal population.
- The Federal population represents 9.5% of total major diagnostic category spend.
- High Cost Claimants (defined as members with claims greater than $75k) represented 3.7% of total membership and 49% of spend.



Plan Year Statistics

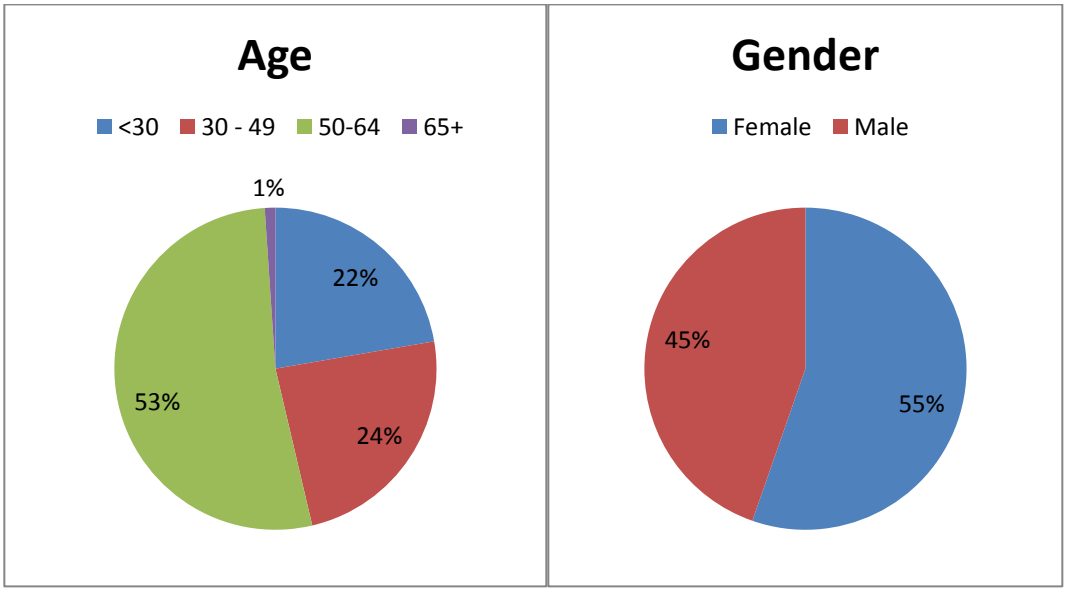
Enrollment

Enrollment in the MHIP State program decreased by 18.5% year end over year end. The MHIP Federal Program ended 4/30/14 and its entire population was terminated. The total average enrollment for Fiscal Year 2014 was 17,529 members compared to a total enrollment of 21,753 for Fiscal Year 2013.



Age & Demographics

The average age of MHIP members is 45.9 and the gender distribution is 55.2% female 44.8% male.



Medical and Pharmacy Costs

	State			Federal		
	FY 2013	**FY 2014**	**Change**	**FY 2013**	**FY 2014**	**Change**
Medical Paid	$140,040,420	$132,269,549	-5.5%	$19,832,213	$14,107,437	-28.87%
Medical PMPM	$574.98	$665.29	14.6%	$1,135.02	$1,234	7.13%
Pharmacy Paid	$70,830,467	$65,763,997	-7.1%	$3,186,211	$2,628,115	-19.29%
Pharmacy PMPM	$290.90	$330.61	12.6%	$182.41	$230	21.54%
Total Medical & Pharmacy Paid	$210,870,887	$198,033,887	-6.1%	$23,018,424	$16,735,552	-27.3%

Top Conditions Driving Costs

For the top 5 major diagnostic category costs Neoplasms represent the largest amount spent for both the State and Federal Populations. Decreasing membership, due to the implementation of the ACA and the transition of the PCIP and MHIP+ populations from MHIP to the individual insurance market, account for the majority of the Major Diagnostic Categories showing a decrease in costs in FY 2014 vice FY 2013.

Conditions Driving Costs	FY 2013	FY 2014	
(FY 2014 Categories) Top Ten			
	Plan Paid	Plan Paid	Change in Cost
Neoplasms	$24,749,544	$19,304,963	-22.00%
Diseases of the Genitourinary System	$15,448,762	$18,147,622	17.47%
Diseases of the Musculoskeletal System and Connective	$17,567,474	$15,217,334	-13.38%
Diseases of the Circulatory System	$13,676,704	$13,243,911	-3.16%
Factors Influencing Health Status	$14,672,818	$13,164,761	-10.28%
Diseases of the Digestive System	$10,511,294	$9,818,317	-6.59%
Systems, Signs, and Ill-Defined Conditions	$8,555,365	$9,025,502	5.50%
Injury and Poisoning	$10,178,047	$9,009,127	-11.48%
Mental Disorders	$8,184,804	$7,408,798	-9.48%
Diseases of the Nervous System and Sense Organs	$7,667,567	$4,917,646	-35.86%
Endocrine, Nutritional, Metabolic Diseases and Immunity	$4,765,294	$4,766,280	0.02%
Diseases of the Respiratory System	$5,273,484	$4,183,668	-20.67%
Diseases of the Skin and Subcutaneous Tissue	$2,888,442	$2,940,635	1.81%
Complications of Pregnancy, Childbirth, and the Puerperium	$3,614,504	$2,820,705	-21.96%
Infectious and Parasitic Diseases	$5,418,286	$1,074,513	-80.17%

Top Drugs Utilization and Cost

Top Ten Drugs by Plan Paid –State

Top 10 Drugs by Plan Paid - State					
Drug Name	Therapeutic Category	# Claimants	# Fills	Total Paid	Cost/Fill
ATRIPLA	Antiretrovirals	541	3887	$5,983,622	$1,539
TRUVADA	Antiretrovirals	692	4528	$4,639,089	$1,025
REYATAZ	Antiretrovirals	362	2378	$2,208,684	$929
COMPLERA	Antiretrovirals	215	1312	$2,196,753	$1,674
PREZISTA	Antiretrovirals	358	2232	$2,185,357	$979
STRIBILD	Viral Reproduction Suppressers	172	940	$1,901,943	$2,023
ISENTRESS	Antiretrovirals	273	1855	$1,655,555	$892
EPZICOM	Nucleoside Reverse Transcriptase	270	1720	$1,507,823	$877
HUMIRA	Disease Modifying Anti-Rheumatoid	78	388	$1,476,673	$3,806
ENBREL	Disease Modifying Anti-Rheumatoid	94	501	$1,436,225	$2,867

Top Ten Drugs by Plan Paid—Federal

Top 10 Drugs by Plan Paid - Federal					
Drug Name	Therapeutic Category	# Claimants	# Fills	Total Paid	Cost/Fill
REVLIMID	Antineoplastic - Thalidomide Analogs	3	30	$193,015	$6,434
HUMIRA	Disease Modifying Anti-Rheumatoid	10	51	$177,476	$3,480
COPAXONE	Central Nervous System	4	12	$116,714	$9,726
ATRIPLA	Antiretrovirals	7	64	$73,165	$1,143
NOVOLOG	Insulin Analog	42	184	$68,016	$370
TRUVADA	Antiretrovirals	10	66	$66,104	$1,002
LEVEMIR	Injectable Antidiabetic Agents	47	166	$63,053	$380
XELODA	Antimetabolite - Pyrimidine Analogs	5	24	$58,778	$2,449
SUTENT	Antineoplastic - Protein-Tyrosine Kinase	1	10	$58,011	$5,801
GILENYA	Immunomodulater	1	4	$55,389	$13,847

Comparison of MHIP Federal (PCIP) to other PCIP Programs and MHIP State

Consistent with national PCIP experiences, MHIP Federal enrollees used a higher volume and intensity of services than those in MHIP State. To qualify for the MHIP Federal program, applicants had to have been uninsured for a minimum of six (6) months prior to applying to MHIP Federal and had to have a pre-existing condition. This means that the MHIP Federal program attracted uninsured individuals who had been recently diagnosed with a severe illness or condition that required immediate care or treatment.

Financial Information

Funding
Funding comes from premiums, hospital assessments, a federal grant to high risk pools and investment income.

Premiums
In fiscal year 2013 premiums were $82,863,910 for the MHIP state program. Premiums for the federal pool were $2,786,747.

MHIP Premium and Coverage Subsidy Partners
MHIP accepts premium payments and enrollment referrals from a number of entities.

- The Maryland AIDS Administration, within the Department of Health and Mental Hygiene, subsidizes premiums and prescription drug deductible and copay costs for its members diagnosed with AIDS or HIV who are enrolled with MHIP.

- During fiscal year 2010, MHIP entered into an agreement with the Center for Cancer Surveillance and Control (CCSC) within the Department of Health and Mental Hygiene under which CCSC will pay the premiums and other costs of MHIP members who participate in the Breast and Cervical Cancer Diagnosis and Treatment Program.

- The federal Health Coverage Tax Credit (HCTC) was made available to MHIP members (including their eligible dependents) who qualified for the credit. As part of the implementation of the ACA, the HCTC program ended as of 12/31/13.

- Holy Cross Hospital in Silver Spring, MD provides partial or full premium assistance to MHIP members who were approved for premium assistance by the hospital.

Hospital Assessments to Provide Funding for MHIP
Each year, the Health Services Cost review Commission (HSCRC) assesses a uniform, broad–based, and reasonable amount in hospital rates to operate and administer the Maryland Health Insurance Plan (MHIP) established under Title 14, Subtitle 5 of the Insurance Article. The assessment is a percentage of net patient revenue that may range from 0.8128% to 3.0%. The assessment rate for FY2014 was established at 1.0%. At its February 5, 2014 public meeting, the Health Services Cost Review Commission approved an emergency regulation changing the MHIP assessment from a fixed 1% of hospital net patient revenue to “up to” 1% of net patient revenue. As a result of this change, the Commission reduced payment to MHIP in March, April, May and June 2014 by an aggregate amount of $22,630,978.

During the 2014 Maryland Legislative the MHIP assessment was permanently reduced from 1.0% to 0.3% beginning in October 2014 (Budget Reconciliation and Financing Act of 2014 (SB 172/HB 162).

Federal Grant

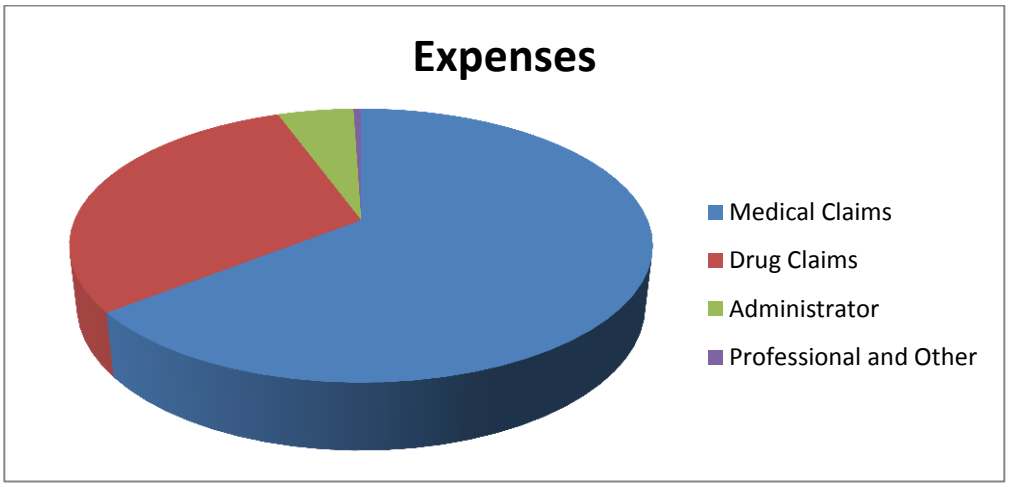
Grants to help cover losses and bonus grants to fund premium reductions or other program enhancements were authorized by Congress for federal years 2006 – 2012 if funds were appropriated in the federal budget for each year. During fiscal year 2014, MHIP received revenues from a federal bonus grant award of $799,371 for the low income premium subsidy program and $883,988 for operational losses related to a federal grant received for operating losses incurred during fiscal year 2013.

Investment Income

Interest income for MHIP State is $1,488,474 and $87,618 for the federal pool.

Expenses

Claim payments of $214,769,098 were the largest expense of the MHIP program followed by TPA administration costs of $11,465,665. Professional (staff) and other costs accounted for $1,164,674.



Audited Financial Report

Each year MHIP secures an independent financial audit of its operations. Refer to Appendix A for the Fiscal Year 2014 Audited Financial Statements.

Maryland Health Insurance Plan Board of Directors

T. Eloise Foster is the first and only African-American woman in the nation to serve as a chief state budget officer, having been appointed as Secretary of the Maryland Department of Budget and Management in 2000. Although she left the position in early 2003, she returned in 2007 when she was appointed by Governor Martin O'Malley.

Secretary Foster serves as the chief fiscal advisor to the Governor responsible for development and management of Maryland's $37 billion operating and $1.6 billion capital budgets, a personnel system governing approximately 79,000 employees and an employee and retiree benefits program covering more than 230,000 lives. As Budget Secretary, Ms. Foster led efforts to balance the State budget during the worst recession since the Great Depression and served as the chief architect of fiscal policies to eliminate Maryland's long-term structural deficit, reduce spending, address unfunded liabilities, and protect the State's Triple A bond rating.

Ms. Foster is an honorary lifetime member of the National Association of State Budget Officers and a member of the National Forum for Black Public Administrators. She is a member of Alpha Kappa Alpha Sorority, and has served on the Howard University Cancer Center Advisory Board, the Seton Keough School Board, and the Arts and Humanities Council of Montgomery County. Ms. Foster was named one of Maryland's Top 100 Women in 2002, 2007 and 2010, qualifying her for entrance into the Circle of Excellence. In May 2010, she was honored by the YWCA at their annual Leader Lunch as one of the organization's Academy of Leaders. In 2012, she received the Shining Star Award from the National Organization of Black Elected Legislative Women. *The Daily Record* named her one of the Most Influential Marylanders of 2013.

Ms. Foster holds a B.A. degree in Business Administration from Howard University, an M.B.A from American University, and has completed Harvard University's Senior Executives in State and Local Government Program.

Bradley Herring, Ph.D., is an Associate Professor in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health in Baltimore and is the Director of the department's Ph.D. Program in Health Economics and Policy. He is an Elected Member to the National Academy of Social Insurance, and is the Chair of the Board of Directors for the Maryland Health Insurance Plan (MHIP), the state's high-risk pool for medically-uninsurable residents. Prior to arriving at Johns Hopkins University, Dr. Herring served for a year with the White House's Council of Economic Advisers, was an

assistant professor at Emory University's School of Public Health, and received a two-year RWJF Scholars in Health Policy fellowship at Yale University. He earned his Ph.D. in health economics from the Wharton School at the University of Pennsylvania, and has a bachelor's degree in biomedical engineering from Tulane University.

Dr. Herring's research focuses on a number of economic and public policy issues related to health insurance coverage and healthcare reform. He has published articles in the *Journal of Health Economics, Health Affairs,* and *New England Journal of Medicine,* and is co-author of the book *Pooling Health Insurance Risks.* His research has been funded by the Robert Wood Johnson Foundation, Organization of Economic Cooperation and Development, U.S. Health and Human Services Assistant Secretary for Planning and Evaluation, and the Agency for Healthcare Research and Quality. His recent research projects have examined healthcare inflation's impact on wage growth; Medicaid managed care, and the individual health insurance market. He is currently working on a long-term project to examine the effect of health insurance coverage on various health outcomes and a short term-project to examine the effects of insurer and hospital competition on private health insurance premiums. Dr. Herring teaches the courses *Introduction to the U.S. Healthcare System* and *Microeconomic Models in Public Health*. He is a frequent commentator on healthcare reform to the media – including quotes in the *New York Times*, *Washington Post,* and *Wall Street Journal* and appearances on C-SPAN, NPR, CBS News Radio, and local television.

Donna Kinzer is the Executive Director of the Maryland Health Services Cost Review Commission (HSCRC). Ms. Kinzer took an extended leave from her position as a Director at Berkley Research Group, where she was a Director leading the Care Improvement and Payment Reform practice, to help lead the HSCRC staff through development and implementation of payment reforms. Ms. Kinzer has focused her career on helping payers, providers, and other health care entities develop and implement new analytics, delivery approaches, payment models, and supporting infrastructure in response to market shifts, changing customer demands, and health care reform. Ms. Kinzer's 30+ years in the health care field has included extensive experience with provider payment model development (hospital, physician, and other sites of care) and extensive use of large health care data sets including medical and pharmaceutical claims, encounters, cost reports, public and private benchmarks, and other data.

Ms. Kinzer spent the first 25 years of her career at Arthur Andersen, where she became a partner in 1987. She has also held positions in the health care practices of Navigant Consulting and Berkeley Research Group. Ms. Kinzer is a graduate of Towson University and is a Certified Public Accountant.

Debora Kuchka-Craig is corporate vice president of Managed Care for MedStar Health located in Columbia, Maryland. In this role, Kuchka-Craig is responsible for the development and execution of third party payer initiatives for MedStar Health. In addition to contract negotiations and payer relations on behalf of MedStar's hospitals, employed physicians, and diversified healthcare businesses, Kuchka-Craig also serves a key role in MedStar's population health initiatives, with executive oversight for the provider network and credentialing functions supporting MedStar Family Choice (a Medicaid plan operating in Maryland and the District of Columbia), and MedStar's Medicaid HMO.

With nearly 30 years of healthcare industry experience, Kuchka-Craig has served as both provider and payer. During the first decade of her career, she was employed by Blue Cross Blue Shield of Maryland (now CareFirst) where she was responsible for directing the health plan's provider network functions.

A fellow of the Healthcare Financial Management Association (HFMA), Kuchka-Craig served as national chair of HFMA, from 2010-2011, leading the 35,000 member association of healthcare finance professionals. Prior roles include serving as HFMA's national chair-elect, secretary-treasurer, a three-year term on the national board of directors, and chair of the National Board of Examiners. She has been recognized for outstanding leadership by the association with various awards, including the Follmer Bronze, Reeves Silver, Muncie Gold, and Medal of Honor merit awards.

Kuchka-Craig currently serves the citizens of Maryland as an appointee on the Maryland Health Insurance Plan Board. A past recipient of Maryland's Top 100 Women award, she has served on numerous community boards and organizations including United Cerebral Palsy of Central Maryland and Leadership-Baltimore County.

Kuchka-Craig received her Bachelor of Arts degree cum laude from Lehigh University, and a Master of Science in health planning and administration from The Johns Hopkins School of Hygiene and Public Health, Baltimore, Maryland (now the Bloomberg School of Public Health).

Gregg Martino joined Aetna in 1999 as the Assistant Vice President of Regulatory Affairs, in the Law and Regulatory Affairs division at Aetna. Prior to joining Aetna, Gregg worked for 15 years with the PA Department of Insurance in various capacities, including Deputy Commissioner for Consumer Services, Deputy Commissioner for Rates and forms and served as Acting Commissioner for a brief period of time.

Since joining Aetna Gregg has overseen the policy form filing area and various compliance responsibilities. His current duties and responsibilities include facilitating the relationships with state regulators, serves as the legislative and regulatory contact for Pennsylvania, overseeing the conclusion and finalization of market conduct examinations, Aetna's NAIC representative and lead coordinator, regulatory compliance, participates in regulatory transactions, and participates in various corporate regulatory projects. He serves on various corporate boards including the Board of Directors for Aetna's HMOs across the country. He also serves on the Board of the Maryland Health Insurance Plan, the high risk insurance plan for the state of Maryland.

He attended the University of Scranton and obtained his BS in Public Administration. He received his Masters of Public Administration and graduated with distinguished honors from Pennsylvania State University. Gregg lives in Hershey Pennsylvania with his wife and two children.

Bethany Oldfield is the Insurance Producer representative on the Board of Directors for the Maryland Health Insurance Plan. For over 9 years, Oldfield has served as the Assistant Vice President of Compliance for Insurance Solutions, a benefits consulting firm in Annapolis, Maryland. Oldfield has served as the point person at Insurance Solutions to assist individuals seeking various individual policies, including short-term medical policies, medical and dental individual policies, Medicare and Medicare supplemental policies.

With over 20 years of health insurance industry experience, Oldfield has worked in all facets of the employee benefits industry. She worked as a Group Benefits Representative for CIGNA Healthcare where she was responsible for developing relationships and servicing jumbo, national accounts and then worked as an Account Manager at Aetna Healthcare where she managed and serviced large clients with 1,000+ employees. Oldfield later worked as a Benefits Consultant and Human Resources Administrator for two large employers in the Baltimore area, where she provided benefits-related assistance to employees, coordinated and conducted enrollment activities and helped educate employees about each company's benefits programs.

Oldfield received her Bachelor of Science degree, magna cum laude, from Framingham State University and earned her Certified Employee Benefits Specialist (CEBS) designation from The Wharton School, University of Pennsylvania. She is a licensed producer in Life and Health in the state of Maryland and is an active member of the National Association of Health Underwriters and the Baltimore Association of Health Underwriters.

Joshua M. Sharfstein, M.D., is the Secretary of the Maryland Department of Health and Mental Hygiene. Previously he served as principal deputy commissioner of the U.S Food and Drug Administration 2009-2011 and as the Commissioner of Health in Baltimore, Maryland from December 2005 to March 2009. From July 2001 to December 2005, Dr. Sharfstein served on the Minority Staff of the Committee on Government Reform of the U.S. House of Representatives, working for Congressman Henry A. Waxman. He serves on the Health Information Technology Policy Committee for the U.S. Department of Health and Human Services, the Board on Population Health and Public Health Practice of the Institute of Medicine, and the editorial board of the Journal of the American Medical Association. He is a 1991 graduate of Harvard College, a 1996 graduate of Harvard Medical School, a 1999 graduate of the combined residency program in pediatrics at Boston Medical Center and Boston Children's Hospital, and a 2001 graduate of the fellowship program in general pediatrics at the Boston University School of Medicine. Dr. Sharfstein lives with his family in Baltimore, Maryland.

Isazetta A. Spikes is the Director of Grants for Catholic Charities of Baltimore. She is a Certified Fund Raising Executive (CFRE) with 25 years of experience in successful nonprofit fundraising and grantsmanship. Before joining Catholic Charities in 2008, she served as the Director of Annual and Planned Giving at the St. Agnes Foundation. She has previously served as the Director of Development for the Community Law Center, the Prince George's County Chapter of the American Red Cross and as National Membership Director for the National Association for the Advancement of Colored People (NAACP). She currently serves as the Health Chair for the Maryland State Conference of NAACP. In 2013, she was awarded the Dr. Montague Cobb Award for outstanding health Care Advocacy at the NAACP's national Convention in Orlando Florida. In addition, she is serving as a Consumer Member of MHIP Board, she is the Secretary of the New Pathways Board, an Executive Committee Member of the Maryland State Conference of NAACP Branches as well as the Treasurer of the Maryland Association of Fundraising Professionals (AFP).

Michael "Ben" Steffen serves as the Executive Director of the Maryland Health Care Commission. The Maryland Health Care Commission is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access to health care and health care coverage in Maryland. The MHCC administers the certificate of need program, Maryland small group insurance market

reforms, the establishment of Maryland's Health Information Exchange, and quality reporting initiatives for hospitals, nursing homes, and health plans. Prior to assuming this position, he served as the Director of the Commission's Center for Information Services and Analysis. This Center has analytic and operational responsibilities for health care practitioner initiatives in the state including development of an All Payer Data Base and the Patient Centered Medical Home Program. Mr. Steffen serves as a spokesperson for the Commission at state and national levels on state health care expenditures, physician work force, physician uncompensated care, and information security. Before joining the MHCC, he served as a budget analyst in the Health, Housing, and Income Security Division of the Congressional Budget Office, among activities he worked on the modeling that produced the estimates of reforms that ultimately led to the Medicare Prospective Payment System. Mr. Steffen holds a Master's Degree from American University and has completed post-graduate work at the University Of Michigan. He is a former Peace Corps volunteer to Nepal.

Scott Afzal is a Partner at Audacious Inquiry, a health information policy and technology company. Scott has also served as the Program Director of Maryland's statewide health information exchange (HIE) planning and deployment efforts since the inception of CRISP, the state-designated entity for HIE. His responsibilities include managing the roll-out of CRISP's HIE network and leading the development of new service offerings. He has also managed the implementation of large scale master data management platforms, focused on patient and provider identity management. Scott is a noted speaker on health information exchange, having presented at regional and national health IT conferences. Prior to joining Audacious Inquiry, he served as a Business and Systems Integration Consultant with Accenture. Scott holds a BSBA in Business Management from Bucknell University.

This organization shall be known as the Board of Directors of the Maryland Health Insurance Plan (MHIP), hereinafter to be referred to as the "Board". The board operates as a nonprofit, unincorporated public entity created pursuant to, §§ 14-501 through 14-515 of the State Insurance Article, Md. Code Annotated.

APPENDIX A

MARYLAND HEALTH INSURANCE PLAN
Baltimore, Maryland

STATUTORY BASIS FINACIAL STATEMENTS
June 30, 2013 and 2014

CliftonLarsonAllen

Independent Auditors' Report

CliftonLarsonAllen LLP
www.cliftonlarsonallen.com

To the Board of Directors
Maryland Health Insurance Plan
Baltimore, Maryland

We have audited the accompanying statutory statements of admitted assets, liabilities and net assets of the Maryland Health Insurance Plan (MHIP or the Plan) as of June 30, 2014 and 2013, and the related statements of operations and changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting practices prescribed or permitted by the Maryland Insurance Administration (the Administration). Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis of Accounting

We draw attention to Note 2 of the statutory financial statements, which describe the basis of accounting. The statutory financial statements were prepared on the basis of accounting practices prescribed or permitted by the Administration, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America.

Opinion

In our opinion, the financial statements referred to in the first paragraph present fairly, in all material respects, the admitted assets, liabilities, and net assets of the Maryland Health Insurance Plan as of June 30, 2014 and 2013 and the results of its operations and its cash flows for the years then ended, on the basis of accounting practices prescribed or permitted by the Administration as described in Note 2.

Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Plan's statutory financial statements. The supplementary information listed on pages 17 through 20, is presented for purposes of additional analysis and are not a required part of the statutory financial statements.

The supplementary information listed on pages 17 through 20 is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the statutory financial statements. Such information has been subjected to the auditing procedures applied in the audit of the statutory financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory financial statements or to the statutory financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary statements are fairly stated, in all material respects, in relation to the statutory financial statements as a whole.

Restriction on Use

This report is intended solely for the information and use of the Board of Directors and management of MHIP, the U.S. Department of Health and Human Services, and the Maryland Insurance Agency, and is not intended to be and should not be used by anyone other than these specified parties.

CliftonLarsonAllen LLP

Baltimore, Maryland
September 29, 2014

STATUTORY FINANCIAL STATEMENTS

MARYLAND HEALTH INSURANCE PLAN
STATUTORY STATEMENTS OF ADMITTED ASSETS, LIABILITIES AND NET ASSETS
June 30, 2014 and 2013

ADMITTED ASSETS

	2014	2013
Cash and cash equivalents	$ 164,539,687	$ 184,616,802
Receivables:		
Assessments	18,984,076	21,141,357
Contract - U.S. Department of Health and Human Services	178,615	2,195,862
Federal grants	883,988	1,832,511
Premiums	239,334	712,304
Pharmaceutical rebates	873,000	464,400
Other current assets	5,583	24,713
TOTAL ADMITTED ASSETS	$ 185,704,283	$ 210,987,949

LIABILITIES AND NET ASSETS

LIABILITIES		
Loss reserves and loss adjustment expenses	$ 7,842,000	$ 18,721,000
Deferred premium tax revenue	4,500,000	4,500,000
Premium subsidies payable	8,389,188	5,985,278
Premiums received in advance	3,891,509	6,877,323
Accounts payable and accrued expenses	1,168,938	1,649,377
Due to CareFirst, BlueCross/BlueShield	2,945,562	9,132,263
Other liabilities	10,000	10,000
Due to State of Maryland	2,956,023	3,933,989
Total liabilities	31,703,220	50,809,230
NET ASSETS		
Unreserved and undesignated	154,001,063	160,178,719
TOTAL LIABILITIES AND NET ASSETS	$ 185,704,283	$ 210,987,949

The accompanying notes are an integral part of these financial statements.

MARYLAND HEALTH INSURANCE PLAN
STATUTORY STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
Years Ended June 30, 2014 and 2013

	2014	2013
PREMIUMS AND OTHER REVENUES		
Premiums	$ 85,650,657	$ 102,459,424
Contract revenues - U.S. Department of Health and Human Services	15,400,287	19,792,152
Interest income	1,724,390	1,846,587
Federal grants	1,683,359	2,224,943
	104,458,693	126,323,106
BENEFITS PAID OR PROVIDED		
Loss and loss adjustment expenses	201,285,587	228,466,764
Premium subsidy expense	15,229,643	13,476,799
	216,515,230	241,943,563
INSURANCE EXPENSES AND OTHER DEDUCTIONS		
Program administration expenses	11,465,665	14,020,599
Professional and other expenses	1,164,674	1,097,325
Write-off of uncollectible premiums	1,893,644	2,649,108
	14,523,983	17,767,032
Loss from operations	(126,580,520)	(133,387,489)
NON-OPERATING REVENUES		
Assessments	103,829,244	126,801,480
Premium taxes	18,000,000	18,000,000
	121,829,244	144,801,480
Change in net assets	(4,751,276)	11,413,991
NET ASSETS, beginning of year	160,178,719	157,445,921
TRANSFERS FROM MHIP NET ASSETS		
State of Maryland Medical Assistance Program	-	(4,500,000)
State of Maryland General Fund	(1,000,000)	-
State of Maryland Kidney Disease Program	-	(4,202,109)
CHANGE IN NON-ADMITTED ASSETS	(426,380)	20,916
NET ASSETS, end of year	$ 154,001,063	$ 160,178,719

MARYLAND HEALTH INSURANCE PLAN
STATUTORY STATEMENTS OF CASH FLOWS
Years Ended June 30, 2014 and 2013

	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES		
Premiums received	$ 81,244,169	$ 101,237,592
Contract revenues received - U.S. Department of Health and Human Services	17,417,534	19,232,798
Federal grant funds received	2,631,882	2,366,897
Interest income received	1,724,390	1,846,587
Premiums subsidy paid	(12,825,733)	(16,198,290)
Program administration, professional and other	(19,278,349)	(11,825,929)
Benefits paid	(212,999,567)	(232,104,348)
Net cash used in operations	(142,085,674)	(135,444,693)
FINANCING AND MISCELLANEOUS ACTIVITIES		
Other cash provided (applied)		
Assessments received	105,986,525	126,500,100
Premium taxes received	18,000,000	18,000,000
(Repayment of)/ Advance funding provided by the State of Maryland	(977,966)	1,668,634
Net transfers from net assets	(1,000,000)	(8,702,109)
Net cash provided by financing and miscellaneous activities	122,008,559	137,466,625
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(20,077,115)	2,021,932
CASH AND CASH EQUIVALENTS, beginning of year	184,616,802	182,594,870
CASH AND CASH EQUIVALENTS, end of year	$ 164,539,687	$ 184,616,802

MARYLAND HEALTH INSURANCE PLAN

NOTES TO STATUTORY FINANCIAL STATEMENTS

NOTE 1 – NATURE OF OPERATIONS

Maryland Health Insurance Plan (MHIP or the Plan) was established by the Maryland General Assembly in 2002 under Chapter 153 of the Acts of 2002, the Health Insurance Safety Net Act. Chapter 259, Acts of 2008, *"Maryland Health Insurance Plan - Status, Operation & Regulation,"* transferred MHIP from the Maryland Insurance Administration (the "Administration") and established MHIP as an independent unit of the State Government, effective October 1, 2008.

MHIP is a full-risk, state sponsored health plan created to decrease uncompensated health costs by providing access to affordable, comprehensive health benefits for medically uninsurable residents, as defined by Maryland law. MHIP superseded the Substantial Available and Affordable Coverage (SAAC) open enrollment program operated by commercial insurance carriers in Maryland and also functions as a state alternative mechanism in accordance with federal requirements under the Health Insurance Portability and Accountability Act (HIPAA). Policyholders currently pay premiums that are no more than 150% of the standard risk rate for individual health insurance sold in Maryland. MHIP also derives funding from annual assessments on net patient revenue of Maryland hospitals.

MHIP oversees the operation of the State's Senior Prescription Drug Assistance Program (SPDAP). The purpose of SPDAP is to subsidize the costs associated with participating in Medicare Part D for eligible individuals. The subsidy provided to Medicare Part D enrollees by SPDAP qualifies it as a State Pharmaceutical Assistance Program (SPAP) pursuant to federal law. SPDAP assists individuals with incomes below 300 percent of the federal poverty level who enroll in Medicare Part D by subsidizing member premiums. SPDAP also subsidizes coinsurance costs incurred in the Medicare Part D coverage gap, or so-called "donut hole."

On March 23, 2010, the President of the United States of America signed into law H.R. 3590, the Patient Protection and Affordable Care Act, Public Law 111-148 (the "ACA") as amended by the Health Care and Education Recovery Act of 2010; Section 1101 of the ACA established a temporary high risk health insurance pool program to provide health insurance coverage to currently uninsured individuals with pre-existing conditions as a transition to the broader market and health care reforms scheduled to take effect in January 2014. The ACA authorized the United States Department of Health and Human Services (HHS) to carry out the program directly, or through contracts with states or private, non-profit entities.

On July 1, 2010, MHIP entered into a contract with HHS to implement, in the State of Maryland, the temporary federal high risk pool program established by Section 1101 of the ACA, thus creating the Temporary Federal High Risk Health Insurance Pool Program of the Maryland Health Insurance Plan (the "Federal Pool"). Under the contract, MHIP is responsible for administering all aspects of the Federal Pool and has contracted to do so using its existing arrangements with third parties, internal staffing and ongoing governance by its Board of Directors. In connection with the contract, HHS awarded the State of Maryland approximately $56.75 million (as amended) to fund the net operating losses of the Federal Pool.

The Federal Plan was originally scheduled to end on December 31, 2013 and the enrollees were expected to transition into the Maryland Health Exchange. The Federal Government extended benefits coverage to enrollees for an additional four months in 2014, to help ensure they did not experience a break in health coverage as they transitioned to other coverage through the Health Insurance Marketplace. During the year ended June 30, 2014 plan members were notified that claims incurred subsequent to April 30, 2014 would no longer be reimbursed

NOTE 1 – NATURE OF OPERATIONS (CONTINUED)

by the Plan. To cover additional expenses incurred by the Plan, HHS increased the contact award amount from $49.2 to $56.75 million. Management of the Plan is currently liquidating claims incurred prior to the termination date, and believes the increase in contract award and MHIP future operating reserves will be sufficient enough to fund all plan expenses. As of June 30, 2014, the balance outstanding on the HHS contract was approximately $3.6 million.

The laws governing MHIP are codified at Title 14, Subtitle 5 of the Insurance Article of the Maryland Annotated Code (the "Code"). Section 14-504 of the Code establishes the MHIP Fund. Member premiums, premium tax revenue for the SPDAP, the annual assessment on hospitals, and amounts deposited pursuant to Section 14-513, among other sources of revenue specified under Section 14-504(b), constitute the MHIP fund.

Under the Code, upon termination of MHIP, the Maryland General Assembly will legislate what is to be done with any funds held by MHIP after payment of all claims and expenses.

NOTE 2 – PERMITTED STATUTORY ACCOUNTING PRACTICES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Permitted Statutory Accounting Practices

The Plan, domiciled in Maryland, prepares statutory financial statements in accordance with the accounting practices prescribed or permitted by the administration. Prescribed statutory accounting practices include a variety of publications of the National Association of Insurance Commissioners (NAIC), as well as state laws, regulations and general administrative rules. Permitted statutory accounting practices encompass all accounting practices not so prescribed.

Use of Estimates

The preparation of statutory financial statements in conformity with accounting practices prescribed or permitted by the Administration requires management to make estimates and assumptions that affect the reported amounts and disclosures in the statutory financial statements. These estimates and assumptions by management could change in the future as more information becomes available. Actual results could differ from the estimates and assumptions used by management.

Basis of Presentation

The accompanying statutory financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Administration, which practices differ from accounting principles generally accepted in the United States of America (GAAP). The more significant variances from GAAP are:

Non-admitted Assets: Certain assets designated as "non-admitted," principally receivables over ninety days, if any are excluded from the Statements of Admitted Assets, Liabilities and Net Assets and directly charged or credited to net assets. Under GAAP, such assets may be included in the balance sheet, net, of specific

NOTE 2 – PERMITTED STATUTORY ACCOUNTING PRACTICES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation (Continued)

Non-admitted Assets (continued)
reserves. The Plan held no non-admitted assessments receivable over ninety days; premiums receivable over ninety days totaling $45,853 and $12,075, and pharmaceutical rebates receivable over ninety days totaling $1,321,400 and $928,800 as of June 30, 2014 and 2013, respectively. Net non-admitted assets credited (charged) to net assets totaled $(426,380) and $20,916 for the years ended June 30, 2014 and 2013, respectively.

Statements of Cash Flows: Cash and cash equivalents in the Statements of Cash Flows represent cash deposits, savings accounts and certificates of deposit in banks or other similar financial institutions with initial maturities of one year or less. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less.

The effects of the foregoing variances from GAAP on the accompanying statutory financial statements have not been determined. Other significant accounting practices are as follows:

Assets

Assets are stated at admitted asset value, which is the value prescribed or permitted by the Administration.

Cash and Cash Equivalents

All highly liquid investments with original maturities of one year or less at acquisition are considered to be cash equivalents and cost approximates fair value.

Premiums Receivable

Premiums are received monthly and are recognized as revenue over the policy period. Premiums received in advance represent the portion of premiums received that relate to future policy periods.

Contract Receivable – U.S. Department of Health and Human Services

The Federal Pool is funded by a $56.75 million (as amended) allocation included in a contract between MHIP and HHS. Amounts are available to be requisitioned on a continuous basis to fund the difference between premiums collected and claims paid plus allowable administrative costs incurred, as defined in the contract. Revenue is recognized to the extent that eligible expenditures have been paid by the Federal Pool.

Pharmaceutical Rebates Receivable
Pharmaceutical rebates receivable represents an estimate of pharmaceutical rebates earned but not yet received for the three month periods ended June 30, 2014 and 2013, respectively, based on historical information including contractual changes in rebate amounts, seasonality differences, changes in premium revenue and changes in utilization of drugs with varying rebate levels. Income from pharmaceutical rebates is recognized by MHIP as earned and is reported as a reduction to claims expense.

NOTE 2 – PERMITTED STATUTORY ACCOUNTING PRACTICES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Federal Grants Receivable

Grants are generally considered to be exchange transactions in which the grantor requires the performance of specified activities. Entitlement to these grants is based on the expenditure of funds in accordance with grant restrictions and therefore, revenue is recognized once MHIP is notified it has been approved to receive the grant to the extent of grant expenditures for those grants.

During fiscal year 2014, MHIP reported revenues from a federal bonus grant award of $799,371 for the low income premium subsidy program and of $883,988 related to a federal grant received for operating losses incurred during fiscal year 2013. During fiscal year 2013, MHIP reported revenues from a federal bonus grant award of $785,565 for the low income premium subsidy program and of $1,439,378 related to a federal grant received for operating losses incurred during fiscal year 2012. These federal grant awards are included in federal grant revenues for those respective fiscal years.

Assessments Receivable

Chapter 244, Acts of 2008, "*Health Services Cost Review Commission - Averted Uncompensated Care - Assessment,*" amended subsection 19-219 of the Health - General Article to authorize the Health Service Cost Review Commission to assess a uniform, broad-based, and reasonable amount in hospital rates to; a) reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the General Assembly of 2007, and b) operate and administer MHIP. Hospitals would pay a portion of the assessment reflecting the aggregated reduction in hospital uncompensated care into the Health Care Coverage Fund and the portion of the assessment for operating and administering MHIP assessment funding. The act also sets an assessment floor of 0.8128% of net patient revenue. The overall hospital assessment may not exceed 3% in the aggregate of any hospital's total net regulated patient revenue. Assessments are recognized as non-operating income by MHIP as earned. Assessments receivable represents assessments earned but not yet received as of June 30, 2014 and 2013.

Premium Taxes

Pursuant to Section 14-106(e)(2) of the Insurance Article, CareFirst BlueCross BlueShield ("CareFirst") is required to deposit in the MHIP Fund an amount from its premium tax exemption to administer SPDAP. Pursuant to Chapter 27, Acts of 2012, "*Senior Prescription Drug Program - Sunset Extension,*" and Chapter 119, Acts of 2010, "*Senior Prescription Drug Program - Sunset Extension,*" amounts deposited into the MHIP Fund by CareFirst for the administration of SPDAP totaled $14,000,000 for each of the years ended June 30, 2014 and 2013. Chapter 557, Acts of 2008, "*Senior Prescription Drug Assistance Program - Subsidy for Medicare Part D Coverage Gap and Sunset Extension*" provides that, among other things, beginning January 1, 2009, and for each calendar year thereafter, that if CareFirst has a surplus that exceeds 800% of the consolidated risk-based capital requirements applicable to the corporation in the immediate preceding calendar year, CareFirst shall transfer $4,000,000 to subsidize a Medicare D benefits gap for costs incurred by SPDAP members.

NOTE 2 – PERMITTED STATUTORY ACCOUNTING PRACTICES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Premium Taxes (Continued)

Chapter 734, Acts of 2009, "*Health Insurance - Senior Prescription Drug Assistance Program - Funding*" provides that the $4,000,000 in new funding from CareFirst, pursuant to Chapter 557, Acts of 2008, is a sum to be paid in addition to the $14,000,000 subsidy that CareFirst already provides to SPDAP. The enactment also made the following technical and procedural changes to the funding process to address the timing of the transfer of funds: the enactment requires CareFirst to notify SPDAP by September 1 of each year whether CareFirst will provide the additional funding to the program during the calendar year that starts on the immediately following January 1. It also requires CareFirst to pay the additional funding in quarterly installments of $1,000,000, beginning not later than October 1 for the calendar year that starts on the immediately following January 1.

Chapter 84, Acts of 2014, *"Senior Prescription Drug Program - Sunset Extension,"* requires the premium tax subsidy of $14,000,000 to be provided to SPDAP through fiscal year 2017.

Amounts deposited into the MHIP fund by CareFirst to fund the administration of SPDAP totaled $14,000,000, in each of the years ended June 30, 2014 and 2013. Amounts deposited into the MHIP fund to subsidize the Medicare Part D coverage gap subsidy totaled $4,000,000, in each of the years ended June 30, 2014 and 2013.

Losses, Loss Adjustment Expenses and Loss Reserves

The liability for losses and loss adjustment expenses consists of an aggregation of the estimated liability for incurred losses on claims that are known to the Plan as of the reporting date (claims payable) and an aggregate estimate of the liability for losses and loss adjustment expenses (LAE) incurred, but not reported, as of the same date. While information is available for the known losses, the liability for which has been established on a case-by-case basis, the unknown losses are based on the best estimate of such liabilities. Although MHIP considers its experience and industry data in determining such reserves, assumptions and projections as to future events are necessary in making these determinations, and ultimate losses may differ significantly in the near term from amounts projected. The effects of changes in reserve estimates are included in results of operations in the period in which estimates are changed. Reserves are not discounted.

Net Assets

Net assets represent the resources available and may be used to fund the liability for unreported losses and LAE, future operating deficiencies, or other specific uses designated by the Board of Directors or the Legislature of the State of Maryland. Net assets can be reserved or designated for specific purposes pursuant to legislative authority.

Coordination of Benefits

Funds obtained through the coordination of benefits with other providers of health care services are included as a reduction of operating losses.

NOTE 2 – PERMITTED STATUTORY ACCOUNTING PRACTICES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Income Tax Status

MHIP meets the definition of a 501(c)(26) entity under the Internal Revenue Code and is, therefore, exempt, from federal income taxes. MHIP is not subject to Maryland state income taxes. Accordingly, the accompanying financial statements do not include a provision or a liability for income taxes.

NOTE 3 – CONCENTRATIONS OF CREDIT RISK

The Plan's financial instruments that are exposed to concentrations of credit risk consist primarily of the following:

Cash and cash equivalents - The Plan has cash balances in certain financial institutions in amounts which occasionally exceed federal deposit insurance limits. The financial stability of these institutions is continually reviewed by management. Effective December 31, 2010, and extending through December 31, 2012, all non-interest-bearing transaction accounts are fully insured by the Federal Deposit Insurance Corporation (FDIC) regardless of the balance of the account. As of June 30, 2014, all noninterest-bearing transaction accounts are insured up to $250,000 per account. As of June 30, 2014, MHIP had deposits of $28,944,226 that exceeded the FDIC coverage. As of June 30, 2013, MHIP had deposits of $6,406,369 that exceeded the FDIC coverage. However, the Plan has not experienced any losses in such accounts and believes that its cash and cash equivalents are not exposed to significant credit risk.

Assessments receivable - Assessments are receivable from multiple hospitals. Included in assessments receivable is an amount from one hospital accounting for approximately 15% and 13% of total assessments receivable at June 30, 2014 and 2013, respectively. Potential credit losses are considered minimal by management.

Contract receivable - The contract receivable is due from a single agency of the U.S. Government at June 30, 2014 and 2013. Potential credit losses are considered minimal by management.

Premiums receivable - Premiums are receivable primarily from insured individuals and potential credit losses are considered minimal by management.

Management has not recorded an allowance for potential credit losses on any of the above receivables.

NOTE 4 – ADMINISTRATIVE SERVICE PROVIDERS

MHIP is required by law to contract with a third-party administrator. As of July 1, 2007, CareFirst has been MHIP's third-party administrator, and is currently obligated to continue in that capacity through December 31, 2014 and subsequent run out. Under the terms of the contract, CareFirst is responsible for all operational functions of the MHIP Plan, including marketing, receiving applications, determining eligibility, enrollment, issuance of certificates, collection

NOTE 4 – ADMINISTRATIVE SERVICE PROVIDERS (CONTINUED)

of premiums, administering the provider network, data collection, case management, financial tracking and reporting, payment of claims, reporting to the MHIP Board, and premium billing. In exchange for those services, CareFirst is paid a monthly administrative fee for each member and a monthly producer referral fee for each accepted application assisted by a producer. When claims exceed premiums, CareFirst is reimbursed by MHIP.

MHIP is also required by law to contract with a third-party administrator to administer SPDAP. The MHIP Board contracted with Pool Administrators, Inc. (PAI) as contract administrator of SPDAP effective January 1, 2008, and is currently obligated to continue in that capacity through December 31, 2016. Under the terms of the agreement, PAI is responsible for implementing and administering SPDAP in accordance with Title 14, Subtitle 5, Part II of the Maryland Insurance Article, and in a manner that ensures that SPDAP remains a federally-qualified SPAP. In exchange for these services, PAI is paid administrative fees.

CareFirst as one of MHIP's third party administrators, carries out substantially all operational functions of the Federal Pool including marketing, receiving applications, determining eligibility, enrollment, issuance of certificates, billing and collection of premiums, administering the provider network, data collection, case management, financial tracking and reporting, payment of claims and reporting to the MHIP Board. In exchange for those services, CareFirst is paid a monthly administrative fee for each member and a monthly producer referral fee for each accepted application assisted by a producer.

NOTE 5 – PHARMACEUTICAL REBATES RECEIVABLE

Quarter Ended	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Invoiced / Confirmed	Actual Rebates Collected Within 90 Days of Invoicing / Confirmation	Actual Rebates Collected Within 91 to 180 Days of Invoicing / Confirmation	Actual Rebates Collected More Than 180 Days After Invoicing / Confirmation
6/30/2014	$ 873,000	$ -	$ -	$ -	$ -
3/31/2014	464,400	-	-	-	-
12/31/2013	464,400	-	-	-	-
9/30/2013	464,400	551,785	-	551,785	-
6/30/2013	464,400	-	-	-	-
3/31/2013	464,400	-	-	-	-
12/31/2012	464,400	-	-	-	-
9/30/2012	427,083	427,083	-	427,083	-

NOTE 6 – LOSSES, LOSS ADJUSTMENT EXPENSES AND LOSS RESERVES

The Plan's liability for losses, loss adjustment expenses and loss reserves consists of an aggregation liability for incurred losses on claims that are known to the Plan as of the reporting date (claims aggregate estimate of the liability for losses incurred (loss reserves) and loss adjustment expenses incurred but not reported to the Plan, as of the same date. The following is a summary of activity losses, expenses and loss reserves:

	2014	2013
Beginning of year	$ 18,256,600	$ 21,915,100
Incurred (recovered) related to:		
Current year	203,828,993	234,613,550
Prior years	(2,543,406)	(6,146,786)
Total	201,285,587	228,466,764
Change in non-admitted assets - Pharmaceutical rebates	426,380	(20,916)
Paid related to:		
Current year	(196,821,973)	(216,336,034)
Prior years	(16,177,594)	(15,768,314)
Total	(212,999,567)	(232,104,348)
Balance, end of year	$ 6,969,000	$ 18,256,600

The provision for loss and loss adjustment expenses decreased by approximately $2,543,400 and $6,147,000 in fiscal years 2014 and 2013, respectively, as a result of changes in estimates, and due to lower than anticipated losses incurred in prior years. Incurred losses are presented net of pharmaceutical rebates of approximately $2,676,000 and $1,877,000 for the fiscal years ended June 30, 2014 and 2013, respectively. Paid losses are presented net of pharmaceutical rebates of approximately $2,250,000 and $1,855,000 for the fiscal years ended June 30, 2014 and 2013, respectively.

NOTE 7 – NET ASSETS

Section 11 of Chapter 397, Acts of 2011, “Budget Reconciliation and Financing Act of 2011," provides that, among other things, and notwithstanding any other provision of the law, the Governor may transfer by budget amendment from the SPDAP account of the MHIP Fund established under Section 14-504 of the Insurance Article to the Kidney Disease Program established under Title 13, Subtitle 3 of the Health - General Article up to $1,500,000 in fiscal year 2012, and up to $3,000,000 in fiscal year 2013. Chapter 1 of the "Budget Reconciliation and Financing Act of 2012" signed on May 22, 2012, repealed and reenacted, with amendments, Section 11 of Chapter 397, Acts of 2011 and now provides, among other things, and notwithstanding any other provision of the law, the Governor may transfer by budget amendment from the SPDAP account of the MHIP Fund to the Kidney Disease Program up to $3,000,000 in fiscal year 2012, and up to $5,000,000 million in fiscal year 2013. Pursuant to this legislation, during fiscal year 2013, designated net assets of SPDAP totaling $4,202,109 were transferred to the Kidney Disease Program.

NOTE 7 – NET ASSETS (CONTINUED)

Section 16 of Chapter 1, Acts of 2012, "Budget Reconciliation and Financing Act of 2012", approved by the governor on May 22, 2012, provides that, among other things, and notwithstanding any other provisions of the law, the Governor may transfer from the SPDAP account of the MHIP fund to the Medical Assistance Program up to $4,500,000 in fiscal year 2013. Pursuant to this legislation, during fiscal year 2013 designated net assets of SPDAP totaling $4,500,000 were transferred to the Maryland General Fund.

Section 9 of Chapter 464, Acts of 2014, "Budget Reconciliation and Financing Act of 2014" provides that, among other things, and notwithstanding any other provision of the law, the Governor may transfer by budget amendment from the SPDAP account of the MHIP Fund to the Maryland General Fund up to $1,000,000 in fiscal year 2014. Pursuant to this legislation, during fiscal year 2014 designated net assets of SPDAP totaling $1,000,000 were transferred to the Maryland General Fund.

NOTE 8 – RELATED PARTY TRANSACTIONS

The State of Maryland receives and disburses cash on behalf of MHIP. The balance of MHIP's cash maintained by the State of Maryland as of June 30, 2014 and 2013 totaled approximately $132,191,000 and $159,826,000, respectively.

NOTE 9 – OPERATING LEASE

MHIP leases office space under an operating lease that expires in June 2016. Future minimum lease payments under this operating lease total $67,350 for fiscal years 2015 through 2016. Rent expense under this lease totaled $67,367 and $68,374 for the fiscal years ended June 30, 2014 and 2013, respectively.

NOTE 10 – CONTINGENCIES

MHIP acknowledges that certain claims and legal actions can arise in the ordinary course of business. Management is currently unaware of any such actions against MHIP.

NOTE 11 – SUBSEQUENT EVENTS

Management evaluated subsequent events through September 29, 2014, the date the statutory financial statements were available to be issued. Events or transactions occurring after June 30, 2014, but prior to September 29, 2014 that provided additional evidence about conditions that existed at June 30, 2014, have been recognized in the statutory financial statements as of and for the year ended June 30, 2014. Events or transactions that provided evidence about conditions that did not exist at June 30, 2014, but arose before the statutory financial statements were available to be issued, have not been recognized in the statutory financial statements as of and for the year ended June 30, 2014.

SUPPLEMENTARY INFORMATION

MARYLAND HEALTH INSURANCE PLAN
STATUTORY STATEMENT OF ADMITTED ASSETS, LIABILITIES AND NET ASSETS BY PROGRAM
June 30, 2014

	MHIP	Federal Pool	SPDAP	Eliminations	Total
ADMITTED ASSETS					
Cash and cash equivalents	$ 145,349,986	$ 2,809,342	$ 16,380,359	$ -	$ 164,539,687
Receivables:					
Assessments	18,984,076	-	-	-	18,984,076
Contract - U.S. Department of Health and Human Services	-	178,615	-	-	178,615
Federal grants	883,988	-	-	-	883,988
Premiums	239,334	-	-	-	239,334
Pharmaceutical rebates	825,000	48,000	-	-	873,000
Due from MHIP Federal	61,601	-	-	(61,601)	-
Other current assets	-	-	5,583	-	5,583
TOTAL ADMITTED ASSETS	$ 166,343,985	$ 3,035,957	$ 16,385,942	$ (61,601)	$ 185,704,283
LIABILITIES AND NET ASSETS					
LIABILITIES					
Loss reserves and loss adjustment expenses	7,681,000	161,000	$ -	$ -	$ 7,842,000
Deferred premium tax revenue	-	-	4,500,000	-	4,500,000
Premium subsidies payable	-	-	8,389,188	-	8,389,188
Premiums received in advance	3,891,509	-	-	-	3,891,509
Accounts payable and accrued expenses	458,271	16,959	693,708	-	1,168,938
Due to CareFirst BlueCross BlueShield	2,927,382	18,180	-	-	2,945,562
Other liabilities	10,000	-	-	-	10,000
Due to State of Maryland	-	2,956,023	-	-	2,956,023
Due to MHIP	-	61,601	-	(61,601)	-
Total Liabilities	14,968,162	3,213,763	13,582,896	(61,601)	31,703,220
NET ASSETS					
Unreserved and undesignated	151,375,823	(177,806)	2,803,046	-	154,001,063
TOTAL LIABILITIES AND NET ASSETS	$166,343,985	$3,035,957	$16,385,942	$(61,601	$185,704,283

MARYLAND HEALTH INSURANCE PLAN
STATUTORY STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS BY PROGRAM
For the Year Ended June 30, 2014

	MHIP	Federal Pool	SPDAP	Total
PREMIUMS AND OTHER REVENUES				
Premiums	$ 82,863,910	$ 2,786,747	$ -	$ 85,650,657
Contract revenues - U.S. Department of Health and Human Services	-	15,400,287	-	15,400,287
Interest income	1,488,474	87,618	148,298	1,724,390
Federal grants	1,683,359	-	-	1,683,359
Total premiums and other revenues	86,035,743	18,274,652	148,298	104,458,693
BENEFITS PAID OR PROVIDED				
Loss and loss adjustment expense	187,161,767	14,123,820	-	201,285,587
Premium subsidy expense	-	-	15,229,643	15,229,643
Total benefits paid or provided	187,161,767	14,123,820	15,229,643	216,515,230
INSURANCE EXPENSES AND OTHER DEDUCTIONS				
Program administration expenses	8,913,520	664,063	1,888,082	11,465,665
Professional and other expenses	449,030	247,780	467,864	1,164,674
Write-off of uncollectible premiums	1,547,827	345,817	-	1,893,644
Total insurance expenses and other deductions	10,910,377	1,257,660	2,355,946	14,523,983
(Loss) Income from operations	(112,036,401)	2,893,172	(17,437,291)	(126,580,520)
NON-OPERATING REVENUES				
Assessments	103,829,244	-	-	103,829,244
Premium taxes	-	-	18,000,000	18,000,000
Total non-operating revenues	103,829,244	-	18,000,000	121,829,244
Change in net assets	(8,207,157)	2,893,172	562,709	(4,751,276)
NET ASSETS, beginning of year	159,996,118	(3,057,736)	3,240,337	160,178,719
TRANSFERS FROM MHIP NET ASSETS				
State of Maryland General Fund	-	-	(1,000,000)	(1,000,000)
State of Maryland Kidney Disease Program	-	-	-	-
CHANGE IN NON-ADMITTED ASSETS	(413,138)	(13,242)	-	(426,380)
NET ASSETS, end of year	$ 151,375,823	$ (177,806)	$ 2,803,046	$ 154,001,063

MARYLAND HEALTH INSURANCE PLAN
STATUTORY STATEMENT OF ADMITTED ASSETS, LIABILITIES AND NET ASSETS BY PROGRAM
June 30, 2013

	MH1P	Federal Pool	SPDAP	Eliminations	Total
ADMITTED ASSETS					
Cash and cash equivalents	$ 167,643,380	$ 2,629,243	$ 14,344,179	$ -	$ 184,616,802
Receivables:					
Assessments	21,141,357	-	-	-	21,141,357
Contract - U.S. Department of Health and Human Services	-	2,195,862	-	-	2,195,862
Federal grants	1,832,511	-	-	-	1,832,511
Premiums	670,522	41,782	-	-	712,304
Pharmaceutical rebates	450,000	14,400	-	-	464,400
Due from MHIP Federal	80,854	-	-	(80,854)	-
Other current assets	20,404	687	3,622	-	24,713
TOTAL ADMITTED ASSETS	$ 191,839,028	$ 4,881,974	$ 14,347,801	$ (80,854)	$ 210,987,949
LIABILITIES AND NET ASSETS					
LIABILITIES					
Loss reserves and loss adjustment expenses	16,117,000	2,604,000	$ -	$ -	$ 18,721,000
Deferred premium tax revenue	-	-	4,500,000	-	4,500,000
Premium subsidies payable	-	-	5,985,278	-	5,985,278
Premiums received in advance	6,603,499	273,824	-	-	6,877,323
Accounts payable and accrued expenses	947,387	79,804	622,186	-	1,649,377
Due to CareFirst, BlueCross/BlueShield	8,165,024	967,239	-	-	9,132,263
Other liabilities	10,000	-	-	-	10,000
Due to State of Maryland	-	3,933,989	-	-	3,933,989
Due to MHIP	-	80,854	-	(80,854)	-
Total Liabilities	31,842,910	7,939,710	11,107,464	(80,854)	50,809,230
NET ASSETS					
Unreserved and undesignated	159,996,118	(3,057,736)	3,240,337	-	160,178,719
TOTAL LIABILITIES AND NET ASSETS	$ 191,839,028	$ 4,881,974	$ 14,347,801	$ (80,854)	$ 210,987,949

MARYLAND HEALTH INSURANCE PLAN STATUTORY STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS BY PROGRAM
For the Year Ended June 30, 2013

	MHIP	Federal Pool	SPDAP	Total
PREMIUMS AND OTHER REVENUES				
Premiums	$ 97,912,838	$ 4,546,586	$ -	$ 102,459,424
Contract revenues – U.S. Department of Health and Human Services	-	19,792,152	-	19,792,152
Interest income	1,433,861	223,417	189,309	1,846,587
Federal grants	2,224,943	-	-	2,224,943
Total premiums and other revenues	101,571,642	24,562,155	189,309	126,323,106
BENEFITS PAID OR PROVIDED				
Loss and loss adjustment expense	204,742,015	23,724,749	-	228,466,764
Premium subsidy expense	-	-	13,476,799	13,476,799
Total benefits paid or provided	204,742,015	23,724,749	13,476,799	241,943,563
INSURANCE EXPENSES AND OTHER DEDUCTIONS				
Program administration expenses	10,891,737	1,272,542	1,856,320	14,020,599
Professional and other expenses	509,451	340,697	247,177	1,097,325
Write-off of uncollectible premiums	2,510,402	138,706	-	2,649,108
Total insurance expenses and other deductions	13,911,590	1,751,945	2,103,497	17,767,032
Loss from operations	(117,081,963)	(914,539)	(15,390,987)	(133,387,489)
NON-OPERATING REVENUES				
Assessments	126,801,480	-	-	126,801,480
Premium taxes	-	-	18,000,000	18,000,000
Total non-operating revenues	126,801,480	-	18,000,000	144,801,480
Change in net assets	9,719,517	(914,539)	2,609,013	11,413,991
NET ASSETS, beginning of year	150,237,561	(2,125,073)	9,333,433	157,445,921
TRANSFERS FROM MHIP NET ASSETS				
State of Maryland Medical Assistance Program	-	-	(4,500,000)	(4,500,000)
State of Maryland Kidney Disease Program	-	-	(4,202,109)	(4,202,109)
CHANGE IN NON-ADMITTED ASSETS	39,040	(18,124)	-	20,916
NET ASSETS, end of year	$ 159,996,118	$ (3,057,736)	$ 3,240,337	$ 160,178,719